Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare North Dallas

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-15-1116-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of service 8/29/14, 8/31/12 were not paid."

Amount in Dispute: $227.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not date stamped as received by DWC MRD until 12/15/14. Consequently, it is not timely as to DOS 8/31/12 per Rule 133.307(c)(1)(A). …Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2012 August 29, 2014	99361 99213	$227.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the guidelines for workers compensation specific codes.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 165 – Payment denied / reduced for absence of, or exceeded referral
   - 219 – Extent of injury

Issues

1. Did the requestor waive their right to medical fee dispute resolution?
2. Did the requestor support services as billed?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;" The date of the services in dispute is August 31, 2012. The date of the benefit review conference was May 24, 2012. Sixty days from the benefit review conference would be July 24, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 15, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services did involve issues identified in §133.307(c)(1)(B) however the request for Medical Fee Dispute Resolution was beyond the 60 days of the Decision and Order. The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

   The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

2. 28 Texas Administrative Code §134.202 (3) states in pertinent part, "Case Management is the responsibility of the treating doctor. Team conferences and phone calls shall include coordination with an interdisciplinary team (members shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program). Documentation shall include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

   (A) the development or revision of a treatment plan;

   (B) to alter or clarify previous instructions;

   (C) to coordinate the care of employees with catastrophic or multiple injuries requiring multiple specialties; or,

   (D) to coordinate with the employer, employee, and/or an assigned medical or vocational case manager to determine return to work options."

   Review of the submitted documentation finds

   a) Treatment plan "unknown"
   b) Comments "will f/u w/pt for status"
   c) Work Status?
   d) Progress: (left blank)

   The Division finds the criteria for the service in dispute is not met as the submitted documentation contained no documented change in the condition of the patient, no treatment plan and no return to work options were indicated. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.